

PRINTED: 10/05/2010 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER (X4) ID PREFIX PROUPER SUMMARY STATEMENT OF DEFICIENCIES PROVIDED METAL TAG FROM INITIAL COMMENTS F 000 INITIAL COMMENTS Complaint investigation #\$ 24173, 24685, 24692, 25902, 25910, 25921, and 25923, were completed at Willows at Winchester Care & Rehabilitation on September 27 - 29, 2010. No deficiencies were cited on complaint investigation #\$ 24173, 25902, 25910, 25921, and 25923, under CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24685 and 24692. F 281 43 220(k)(3)(0) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to follow the care plan for one resident (#3); and failed to follow physician's orders for one resident (#3) of eleven residents reviewed. The findings included: Resident #\$ was admitted to the facility on December 12, 2008, with diagnoses including Hypothyroidism, Cerebral Vascular Accident, and Osteoporosis. Medical record review of the Minimum Data Set dated May 21, 2010, revealed f'…use lift for transfers with assist and cord review of the Care Plan dated June 4, 2010, revealed f'…use lift for transfers with assistance of two."	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER ON 10 INITIAL COMMENTS Complaint investigation #\$ 24173, 24685, 24692, 25990, 25910, 25921, and 25923, were completed at Willows at Winchester Care & Rehabilitation on September 27 - 22, 2010. No deficiencies were cited on complaint investigation #\$ 24173, 2590, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24173, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, 25910, 25921, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #\$ 24178, 25902, and 25923, under CFR Part 493, Requirements for Long Term Care Facilities and preparation and/or execution of this plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction is being submitted in compliance with specific regulatory requirements and			akonto con estamber			,	С		
WILLOWS AT WINCHESTER CARE & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PROPERTY AND FOORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE OF COMPLETION OF LSC LICENTIFYING INFORMATION) PREFIX TAGE PROVIDERS HAND OF CORRECTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DATE OF CROSS-REFER			445319	B. WII	B. WING		09/29/2010		
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS Complaint investigation #'s 24173, 24685, 24692, 25902, 25910, 25921, and 25923, were completed at Willows at Winchester Care & Rehabilitation on September 27 - 29, 2010. No deficiencies were cited on complaint investigation #'s 24173, 25902, 25910, 25921, and 25923, under CFR Part 438, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #'s 24052, 20(1), 3(5) SERVICES PROVIDED MEET SS=D F 281 433, 20(1), 3(1) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to follow the care plan for one resident (#5); and failed to follow physician's orders for one resident (#8) of eleven residents reviewed. The findings included: Resident #5 was admitted to the facility on December 12, 2008, with diagnoses including Hypothyroidism, Cerebral Vascular Accident, and Osteoporosis. Medical record review of the Minimum Data Set dated May 21, 2010, revealed the resident was "total dependence" for transfers. Medical record review of the Care Plan dated June 4, 2010, revealed "use lift for transfers with assistance of two."			ER	32 MEMORIAL DRIVE					
Complaint investigation #s 24173, 24685, 24692, 25910, 25921, and 25923, were completed at Willows at Winchester Care & Rehabilitation on September 27 - 29, 2010. No deficiencies were cited on complaint investigation #s 24173, 25902, 25910, 25921, and 25923, under CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited on complaint investigation #s 24685 and 24692. F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to follow the care plan for one resident (#5); and failed to follow physician's orders for one resident (#8) of eleven residents reviewed. The findings included: Resident #5 was admitted to the facility on December 12, 2008, with diagnoses including Hypothyroidism, Cerebral Vascular Accident, and Osteoporosis. Medical record review of the Minimum Data Set dated May 21, 2010, revealed the resident was "…total dependence" for transfers. Medical record review of the Care Plan dated June 4, 2010, revealed "…use lift for transfers with assistance of two."	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO		N SHOULD BE COI		
	F 281 SS=D	Complaint investigat 25902, 25910, 2592 completed at Willow Rehabilitation on Set deficiencies were cit is 24173, 25902, 2 under CFR Part 483 Term Care Facilities complaint investigat 483.20(k)(3)(i) SER PROFESSIONAL Some and the services provided must meet profession in the facility failed to five facility failed to five sident (#5); and facility failed to five	ation #'s 24173, 24685, 24692, 21, and 25923, were as at Winchester Care & eptember 27 - 29, 2010. No ted on complaint investigation 5910, 25921, and 25923, 3, Requirements for Long as Deficiencies were cited on the cites and 24692. VICES PROVIDED MEET TANDARDS and standards of quality. IT is not met as evidenced accord review, and interview, collow the care plan for one cited to follow physician's ent (#8) of eleven residents and with diagnoses including the cord review and interview, of the Minimum Data Set revealed the resident was" for transfers. We of the Care Plan dated ed "use lift for transfers to."	F2		submitted in compliance with specific regulatory requirement and preparation and/or execut this plan of correction does not constitute admission or agreed by the provider of the facts all or conclusions set forth on the statement of deficiencies F281-D 1. What corrective action(s) whose accomplished for those rest found to have been affected by deficient practice The current plan of care for transfers utilizing a mechanica with assist of two was reviewed the Assistant Director of Nurs 9/29/10 and found that it is be followed for RI# 5.RI# 8 discharged from the facility of 10/7/2009. 2. How you will identify other residents having the potential affected by the same deficient practice and what corrective as will be taken	nts ion of ot ment leged will idents y the al lift ed by es on ing n		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	me-15 00 - 150 0	IULTIPLE CONSTRUCTION		E SURVEY PLETED	
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445319		B. WIN	B. WING		09/29/2010		
	PROVIDER OR SUPPLIER /S AT WINCHESTER	CARE & REHABILITATION CENT	ER	STREET ADDRESS, CITY, STATE, ZIP 32 MEMORIAL DRIVE WINCHESTER, TN 37398	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	70° 10° 10° 10° 10° 10° 10° 10° 10° 10° 1	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	Review of a facility 2010, revealed "r shower chair" Interview on Septer with Certified Nursi station, revealed " helpdid not use the Interview on Septer with the ADON (Asset the ADON's office, follow the care plan resident. Resident #8 was ac 2009, with diagnose Disease (stage III), Vascular Accident at Medical record revier revealed the resider (Basic Metabolic Parents Medical record revier revealed the resident (Basic Metabolic Parents Medical record revier revealed the resident review of the laboration of the last Basic Metabolic Parents Medical record revier revealed the resident revealed the resid	investigation dated July 16, manually lifted resident to mber 28, 2010, at 12:30 p.m., ng Assistant #1, at the nurse's .lifted resident manually with ne full lift" mber 28, 2010, at 2:30 p.m., sistant Director of Nursing) in confirmed the facility failed to for proper transfer of the limitted to the facility on April 4, es including Chronic Kidney Atrial Fibrillation, Cerebral and Hypertension. ew of the physician's order nt was to have a weekly BMP anel). atory report revealed the last eted August 17, 2009. tor of Nursing on Sept 28, in the conference room, implied to the last and the last was August 17, 2009.	F 22	Director Of Nursing/A Director of Nursing/St Development Coordinate conducted an audit on determine the plan of a followed for residents mechanical lifts for training audits were completed Director of Nursing/As Director of Nursing/St Development Coordinate 10/7/10 to determine 1 completed as ordered. The resident of the systematic syou will make to ensure deficient practice does Licensed Nurse/CNA rewas held on 9/30/2010 10/1/2010 per Staff Development Coordinator regarding the plan of care for utility mechanical lifts for training assistance of 2 persons. Nurses were re-trained 10/1/2010 per Staff Development Coordinator regarding 1 being completed as ordered.	aff ator 9/29/2010 to care is being requiring nsfers. Lab by the ssistant aff ator on abs are No other fied to have be put into ic changes e that the not recur e-training and velopment following izing asfers with Licensed on velopment ab tests	10/07/2010	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
41			A. BUILDING B. WING			С	
445319		B. WIN			09	9/29/2010	
NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENT		CARE & REHABILITATION CENT	ER	3	REET ADDRESS, CITY, STATE, ZIP CODE 2 MEMORIAL DRIVE VINCHESTER, TN 37398		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	Review of a facility i 2010, revealed "m shower chair" Interview on Septem with Certified Nursin station, revealed " helpdid not use the Interview on Septem with the ADON (Ass the ADON's office, of follow the care plan resident. Resident #8 was addr 2009, with diagnoses Disease (stage III), A Vascular Accident ar Medical record review revealed the resident (Basic Metabolic Par Review of the laborate BMP lab was completed Interview with Director 2010, at 2:50 p.m., in confirmed the last BM 483.25(h) FREE OF A	nvestigation dated July 16, nanually lifted resident to on the 28, 2010, at 12:30 p.m., or Assistant #1, at the nurse's lifted resident manually with the full lift" The 28, 2010, at 2:30 p.m., istant Director of Nursing) in confirmed the facility failed to for proper transfer of the mitted to the facility on April 4, is including Chronic Kidney Atrial Fibrillation, Cerebral and Hypertension. Who of the physician's order that was to have a weekly BMP arel). The cory report revealed the last atted August 17, 2009. For of Nursing on Sept 28, the conference room, and Plab was August 17, 2009. ACCIDENT	F 22		the intention to maintain the integrity of the processes. 4. How the corrective action will be monitored to ensure the deficient practice will not receive, what quality assurance program will be put into place. The Director Of Nursing/Assi Director Of Nursing/Staff Development Coordinator will perform audits regarding follow the plan of care for utilizing mechanical lifts for transfers weekly x4 weeks then monthly months. The Director of Nursing/Assistant Director of Nursing/Assistant Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator will perform lab audits to determine physician orders are followed weekly x4 weeks then monthly x2 months begin on 10/6/2010. Results to brought forward to Performance Improvement (PI) committee for further recommendations and/o suggestions and follow up as	stant l owing y x2	10/07/2010
	as is possible; and ea	are that the resident as free of accident hazards			needed. The PI committee con of Administrator, Director of Nursing Services, Assistant Director of Nursing Services,	sists	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6R7P11

Facility ID: TN2603

If continuation sheet Page 2 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		8 10 10	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
	*	445319	B. WIN			C			
NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENT				STREET ADDRESS, CITY, STATE, ZIP CODE 32 MEMORIAL DRIVE WINCHESTER, TN 37398					
PREF	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX . (EACH CORRECTIVE ACTION SHO		COMPLETION DATE			
F 28	Review of a facility in 2010, revealed "" Interview on Septem with Certified Nursin station, revealed "	Review of a facility investigation dated July 16, 2010, revealed "manually lifted resident to shower chair" Interview on September 28, 2010, at 12:30 p.m., with Certified Nursing Assistant #1, at the nurse's station, revealed "lifted resident manually with helpdid not use the full lift" Interview on September 28, 2010, at 2:30 p.m., with the ADON (Assistant Director of Nursing) in the ADON's office, confirmed the facility failed to follow the care plan for proper transfer of the		Maintenance Director, Med Director, Business Office M Social Services Director, Addissions/Market Director, Admissions/Market Director, Environmental Ser Director, Staff Development Nutritional Services Director Health Information Manager Therapy Program Manager, Clinical Case Manager, and Coordinator. All members a invited to attend monthly PI Committee meetings.	anager, etivities eting vices r, r,				
F 323 SS=D	2009, with diagnoses Disease (stage III), A Vascular Accident and Medical record review revealed the resident (Basic Metabolic Panel Review of the laborate BMP lab was completed Interview with Director 2010, at 2:50 p.m., in confirmed the last BM 483.25(h) FREE OF A HAZARDS/SUPERVISON The facility must ensure environment remains a as is possible; and each	of the physician's order was to have a weekly BMP el). ory report revealed the last ed August 17, 2009. of Nursing on Sept 28, the conference room, P lab was August 17, 2009. CCIDENT SION/DEVICES re that the resident as free of accident hazards	F 323	F323-D 1. What corrective action(s) be accomplished for those restound to have been affected by deficient practice RI# 9 was discharged from the facility on 3/30/2010. 2. How you will identify other residents having the potential affected by the same deficient practice and what corrective as	e er to be				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				A. BUILDING			С
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	PROVIDER OR SUPPLIER	CARE & REHABILITATION CENTE		32	EET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL DRIVE VINCHESTER, TN 37398		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	c	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	Continued From pa	ige 2	F 3	23	will be taken		
	by: Based on medical rigidity failed to super proper transfer deviresident (#9) of elevant The findings included Resident #9 was acceptember 3, 2008. Hypertension, Congeffect of Cerebral V Osteoarthritis, and I Medical record revied dated October 5, 20 short term memory assist for transfers at Medical record revied October 6, 2009, revealed the transferred using the Review of a facility in 9, 2009, revealed the transferred to a bedical record revied 23, 2009, and after a resident back in bedical revealed to a pain. Continued investigation revealed complain of pain and	Imitted to the facility on with diagnoses including pestive Heart Failure, Late ascular Accident, Pressure Ulcer lower back. The work of the Minimum Data Set 109, revealed the resident had deficit, required extensive and was non ambulatory. The work of the care plan dated wealed the resident was to be a sit to stand mechanical lift. The resident was manually side commode on November as taff members placed and the resident complained of the resident continued to the pain medication was given			Director Of Nursing/Assistant Director of Nursing/Staff Development Coordinator conducted audit on 9/29/2010 determine the plan of care is followed for residents requirismechanical lifts for transfers other residents were identified have been affected. 3. What measures will be purplace or what systematic charyou will make to ensure that deficient practice does not result to the plan of care for utilizing mechanical lifts for transfers assistance of 2 persons with the intention to maintain the intention of the process. 4. How the corrective action will be monitored to ensure the conductor of the process.	t into nges the cur ning with the grity	
	through out the nigh Medical record revie	w revealed the resident was			deficient practice will not rec	ui,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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445319		B. WIN			09/29/2010		
NAME OF PROVIDER OR SUPPLIER WILLOWS AT WINCHESTER CARE & REHABILITATION CENTIL			32 N	ET ADDRESS, CITY, STATE, ZIP CODE MEMORIAL DRIVE NCHESTER, TN 37398			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
Interview with CNA# involved in transferri 23, 2009) on Septenthe conference room transferred the resid without using the medid not fall or hurt the The CNA stated they while the resident without until the resident did not spechurting until the resident did not spechurting until the resident was reported to the resident 23, 2009, and had now with the resident would conference room, remassessed the resident would conference with the Dir September 28, 2010, office, confirmed the for the resident for the re	spital on November 24, 2009 and a fracture of right femur. E2 (one of the CNAs who were ing the resident on November mber 28, 2010 at 12:45 p.m. in noward process of the commode exchanical lift but the resident eir leg during this transfer. It is son the commode and the cifically say their leg was dent was assisted back to the ext the resident's voiced pain nourse. E1 (Licensed Practical Nurse) 210, at 1:00 p.m., in the evening of November of noticed anything abnormal ontinued interview revealed complain of pain but would not ain. Exector of Nursing (DON) on at 1:50 p.m., in the DON's facility had failed to use lift he transfer on November 23, sident's doctor on September revealed "Hard to tell" if the fit could have caused the	F 3.	in the second se	i.e., what quality assurance program will be put into place Director Of Nursing/Assistant Director Of Nursing/Staff Development Coordinator to conduct weekly audits x4 weethen monthly x2 months to be on 10/06/2010 regarding following the plan of care for utilizing mechanical lifts for transfers assistance of 2 persons and beforward to Performance Improvement (PI) committee further recommendations and suggestions and follow up as needed. The PI committee coof Administrator, Director of Nursing Services, Assistant Director of Nursing Services, Maintenance Director, Medica Director, Business Office Marketi Director, Environmental Service Director, Environmental Service Director, Staff Development, Nutritional Services Director, Health Information Manager, Cherapy Program Manager, MDS Coordinator. All members are envited to attend monthly PI Committee meetings.	eks egin owing with rought for or onsists al nager, vities ng ices		